U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 06 September 2005

In the Matter of

DENNIS SWAFFORD,

Claimant

v. Case No. 2003-BLA-06608

MOUNTAIN CLAY, INCORPORATED,

Employer

and

JAMES RIVER COAL COMPANY,

Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-In-Interest

Appearances:	Edmond Collett, Esq. Monica Smith, Esq. Edmond Collett, P.S.C. For the Claimant	John H. Baird, Esq. Lois A. Kitts, Esq. Baird & Baird, P.S.C. For the Employer
Before:	William S. Colwell Administrative Law Judge	

DECISION and ORDER DENYING BENEFITS

INTRODUCTION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act (the "Act"), 30 U.S.C. §§ 901 *et. seq*. Benefits under the Act are awarded to coal

miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners who were totally disabled due to pneumoconiosis at the time of their deaths (for claims filed prior to January 1, 1982), or whose death was due to pneumoconiosis. The Act and its implementing regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of employment in the Nation's coal mines. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant, Dennis Swafford, alleges that he is totally disabled by pneumoconiosis.

The Department of Labor has issued regulations governing the adjudication of claims for benefits arising under the Black Lung Benefits Act at Title 20 of the Code of Federal Regulations. The procedures to be followed and standards applied in filing, processing, adjudicating, and paying claims, are set forth at 20 CFR, Part 725, while the standards for determining whether a coal miner is totally disabled due to pneumoconiosis are set forth at 20 CFR, Part 718.

PROCEDURAL HISTORY

The Claimant, Dennis Swafford, filed this claim for benefits under the Act on September 5, 2001. DX-2. On August 21, 2002, after the initial development of the record, the District Director issued a *Schedule for the Submission of Additional Evidence*. DX-19. The District Director concluded that the Claimant would not be entitled to benefits if a decision on the merits were issued at that time, and also determined that Mountain Clay has been correctly named as the responsible operator. On June 18, 2003, the District Director issued a *Proposed Decision and Order - Denial of Benefits*. DX-29. The District Director found that the Claimant failed to establish any element of entitlement.

By letter, dated June 20, 2003, the Claimant requested a formal hearing. DX-31. Pursuant to this request, this claim was referred on September 3, 2003 to the Office of Administrative Law Judges for a formal hearing. DX-34. I conducted the hearing on this claim on August 3, 2004, in London, Kentucky. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 20 CFR Part 18 (2004). At the hearing, Administrative Law Judge's Exhibit ("ALJX") 1, Director's Exhibits ("DX") 1-34, Claimant's Exhibit ("CX") 1, and Employer's Exhibits ("EX") 1-7 were admitted into evidence without objection. Transcript ("Tr.") at 5-8. The record was held open after the hearing to allow the parties to submit additional argument. Post-hearing argument has been submitted, and the record is now closed.

In reaching my decision, I have reviewed and considered the administrative record as a whole, including all exhibits admitted into evidence, the testimony at the hearing, and the arguments of the parties.

APPLICABLE STANDARDS

Because Claimant filed this application for benefits after March 31, 1980, the regulations set forth at Part 718 apply. *Saginaw Mining Co. v. Ferda*, 879 F.2d 198, 204, 12 BLR 2-376 (6th Cir.1989). This claim is governed by the law of the United States Court of Appeals for the Sixth Circuit, because the Miner was last employed in the coal industry in the Commonwealth of Kentucky within the territorial jurisdiction of that court. *Danko v. Director*, *OWCP*, 846 F.2d 366, 368, 11 BLR 2-157 (6th Cir. 1988). *See Broyles v. Director*, *OWCP*, 143 F.3d 1348, 1349, 21 BLR 2-369 (10th Cir. 1998); *Kopp v. Director*, *OWCP*, 877 F.2d 307, 12 BLR 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 BLR 1-200 (1989) (*en banc*).

In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004). *See Mullins Coal Co., Inc. of Virginia v. Director, OWCP*, 484 U.S. 135, 141, 11 BLR 2-1 (1987); *Jericol Mining, Inc. v. Napier*, 301 F.3d 703, 708, 22 BLR 2-537 (6th Cir. 2002), *cert. denied*, 538 U.S. 906 (2003). *See also Roberts & Schaefer Co. v. Director, OWCP*, 400 F.3d 992, 998 (7th Cir. 2005).

The Claimant has the burden of proving each element of entitlement to benefits by a preponderance of the evidence. *Director*, *OWCP v. Greenwich Collieries* [*Ondecko*], 512 U.S. 267, 18 BLR 2A-1 (1994), *aff'g* . *Greenwich Collieries v. Director*, *OWCP*, 990 F.2d 730, 17 BLR 2-64 (3d Cir. 1993). The failure to prove any requisite element precludes a finding of entitlement. *Anderson v. Valley Camp of Utah*, *Inc*., 12 BLR 1-111 (1989); *Perry v. Director*, *OWCP*, 9 BLR 1-1 (1986) (*en banc*).

ISSUES

The following issues remain for adjudication:

1. Whether the claim was timely filed.
2. Whether the Claimant has pneumoconiosis as defined in the Act and the regulations.
3. Whether his pneumoconiosis arose out of coal mine employment.
4. Whether the Claimant is totally disabled.
5. Whether any total respiratory disability is due to pneumoconiosis.
6. Whether the Claimant's son is a qualifying dependent for the augmentation of benefits.

See DX-34. At the formal hearing, counsel for the Employer withdrew as contested issues the length of coal mine employment, whether Mr. Swafford was a miner, and was so employed after 1969, whether the Employer is the properly designated responsible operator, and whether the Claimant's spouse is a qualifying dependent. Tr. 6-7.

The parties have stipulated to 21 years of qualifying coal mine employment. I find that this stipulation is supported by substantial evidence, and therefore credit Mr. Swafford with 21 years of employment in the Nation's coal mines. *See* DXs-3-5, 8. Tr. 12-13, 26. I also find that Mountain Clay, Inc., is the properly designated responsible operator.

The Employer has also reserved the right to challenge the statute and the Secretary's regulations. These issues are beyond the authority of the Administrative Law Judge and are preserved for purposes of appeal. DXs-20, 34.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

The Claimant testified at the formal hearing and also at a deposition that was recorded on September 6, 2002. DX-7. The Claimant, whose date of birth is November 2, 1945, completed the 7th grade. DX-7 at 9. Mr. Swafford has been married to his spouse, Phyllis Swafford, since 1969, and they live together. Tr. 10. They have three children. Although all of the children are older than 18 years of age, the Claimant testified that his son has been enrolled in college in eastern Kentucky.[1] Tr. 11.

The Claimant recalled that he last worked as a miner in 1996 at Camp Creek in Leslie County. DX-7 at 6. He has been employed in coal mining since 1975 for the same company, although various mine sites would have different names. DX-7 at 13-14; Tr. 15-16. He testified that Mountain Clay was bought out by James River in 1995. Tr. 12. During his coal mine employment, the Claimant has been a heavy equipment mechanic for strip mining operations. DX-7 at 7-8, 15; Tr. 13. This work entailed lifting, packing, and at times required the Claimant to lift items in excess of fifty pounds. DX-7 at 11-12; Tr. 14. Mr. Swafford was responsible for maintaining the equipment both in a shop and in the field, where the extraction of coal took place. It was very dusty at these locations. DX-7 at 10, 45; Tr. 15. He rarely wore a respirator. DX-7 at 48.

The Claimant would work an average of ten hours per day, with an additional two hours required to commute back and forth from the mine. Before the last year in this employment, he would also work overtime. Tr. 28-29. He further testified that he suffers from heart and kidney problems. He has breathing problems, but he is not seeing a specialist for those. His breathing is affected by ordinary activities, and shortness of breath will occasionally interfere with his ability to sleep. DX-7 at 23-24; Tr. 17. He tires easily. Although he rarely took time off from his coal mine work, Mr. Swafford testified that he "struggled" while working because of his breathing. DX-7 at 18; Tr. 26. He now gets tired and becomes short of breath. DX-7 at 37-39. He sometimes requires three pillows to sleep, and suffers from episodes of coughing and wheezing at night. DX-7 at 50. He has never smoked. DX-7 at 23. He did suffer a

[1] I find the Claimant to be a credible witness, and find that his son qualifies as a student and thus is a dependent for purposes of the augmentation of any benefits awarded.

heart attack in 1999, and takes medication for high blood pressure. DX-7 at 24, 26-27. The Claimant also testified that he had been hospitalized for "pneumonia and stuff." DX-7 at 30.

For the past few years, the Claimant has received Social Security ("SSA") disability for his medical problems. DX-7 at 37. He also testified that he received a state black lung lump sum award in 1996. DX-7 at 20-22; Tr. 20-21.

On cross-examination, the Claimant said that he did not receive SSA benefits for his son. He was also questioned extensively about whether he had received, in conjunction with his State claim for black lung benefits, a report that he was totally disabled due to pneumoconiosis, and could not recall whether he had received such a report. Tr. 24-25.

Timeliness

The Employer has contested whether this claim is timely. Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602, 22 BLR 2-288 (6th Cir. 2001).

The Employer has not submitted evidence to rebut the presumption that the claim was timely filed. During cross-examination at the formal hearing, Mr. Swafford's testimony did not establish that he had received a report that he was totally disabled due to coal workers' pneumoconiosis. Although the Claimant said that he received a lump sum award for black lung from the Commonwealth of Kentucky, there has been no evidence to show a medical finding of total respiratory disability related to that proceeding. During his deposition, Mr. Swafford was asked whether he had been told that he was totally disabled by black lung disease when he applied for the State benefits, and he replied "[n]o but I've not discussed it with them[.]" DX-7 at 34. I therefore conclude that this claim is timely.[2]

MEDICAL EVIDENCE

Chest X-rays

Chest x-rays may reveal opacities in the lungs that are caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The applicable standards for x-rays taken subsequent to

[2] Claimant acknowledged that one reason for his delay in applying for federal black lung benefits was because he apparently was advised to await a favorable change in the law. DX-7 at 41.

January 19,2001 are set forth at 20 CFR § 718.102 and Appendix A of Part 718 (2004). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the List of A and B-Readers issued by the National Institute of Occupational Safety and Health (NIOSH). If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A-reader; B= NIOSH certified B-reader; BCR= board-certified in radiology.

A physician who is "board-certified" has received certification in radiology by the American Board of Radiology or the American Osteopathic Association. 20 CFR § 718.202(a)(1)(ii)(C). *See Staton v. Norfolk & Western Railway Co*., 65 F.3d 55, 57, 19 BLR 2-271 (6th Cir. 1995). A "B reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Occupational Safety and Health (NIOSH)[3] and administered by the U.S. Department of Health and Human Services. *See* 20 CFR § 718.202(a)(ii)(E); 42 CFR § 37.51.

Courts generally give greater weight to x-ray readings performed by "B-readers." *See LaBelle Processing Company v. Swarrow*, 72 F.3d 308, 20 BLR 2-76 (3d Cir. 1995). Further, an administrative law judge may properly defer to the readings of the physicians who are qualified as both B-readers and Board-certified radiologists. *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211 (1985). *See Zeigler Coal Co. v. Director*, *OWCP* [*Hawker*], 326 F.3d 894, 899 (7th Cir. 2003). *See generally Mullins Coal Co. v. Director, OWCP*, 484 U.S. at 145 n. 16; *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2, 18 BLR 2-42 (7th Cir. 1993). Finally, a radiologist's academic teaching credentials are relevant to the evaluation of the weight to be assigned to that expert's

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[3] NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U. S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_7_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

conclusions. *See Worhach v. Director*, *OWCP*, 17 BLR 1-105 (1993). An administrative law judge is not required to defer to a radiologist on the basis of academic credentials, however. *Chaffin v. Peter Cave Coal. Co.*, 22 BLR 1-294 (2003). *Cf. Martin v. Ligon Preparation Co.*, 400 F.3d 302, 307 (6th Cir. 2005) (credentials of pulmonary specialist not necessarily superior to those of internist who nevertheless established extensive clinical experience in pulmonary medicine and coal workers' pneumoconiosis).

The following table summarizes the x-ray findings available in this case.

Ex. No.	X-Ray Date Reading Date	Physician	Credentials	Interpretation
DX-10	06-24-02 06-24-02	V. Simpao		1/1, p/p, Quality 1
DX-10	06-24-02 08-10-02	P. Barrett	B/BCR	Quality 1 (quality reading only)
DX-11	06-24-02 10-11-02	A. Poulos	B/BCR	no pneumoconiosis, completely negative
EX-1	08-29-02 08-30-02	Rosenberg	B	0/0, Quality 1
EX-1	02-18-04 02-18-04	Rosenberg	B	0/0, Quality 1

Pulmonary Function Test Evidence

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for pulmonary function studies performed before January 19, 2001, are found at 20 CFR § 718.103 (2000), while the standards applicable to tests administered after that date are set forth at 20 CFR § 718.103 (2004) and Appendix B.

The Secretary's regulations allow for the review of pulmonary function testing by experts who can examine the ventilatory tracings and determine the validity of a particular test. 20 CFR §§ 725.414(a)(2)(ii), 725.414(a)(3)(ii). *See generally* 20 CFR § 718.103 & Part 718, Appendix B; *Director, OWCP v. Siwiec*, 894 F.2d 635, 636, 13 BL.R. 2-259 (3d Cir. 1990); *Ziegler Coal Co. v. Sieberg*, 839 F.2d 1280, 1283,11 BLR 2-80 (7th Cir. 1988). Thus, in assessing the probative value of a clinical study, an administrative law judge must address "valid contentions" raised by consultants who review such tests. *See Old Ben Coal Co. v. Battram*, 7 F.3d at 1276; *Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1137-38 (7th Cir. 1988); *Strako v. Ziegler Coal Co.*,

3 BLR 1-136 (1981). *See also Siegel v. Director, OWCP*, 8 BLR 1-156 (1985) (2-1 opinion with Brown, J., dissenting). *Accord*, *Winchester v. Director, OWCP*, 9 BLR 1-177(1986). In assessing the weight of an expert's review of a clinical test, I must account for that expert's credentials. *See Worley v. Blue Diamond Coal Co.*, 12 BLR 1-20 (1988).

The following chart summarizes the results of the pulmonary function studies available in connection with the current claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).[4] *See Grundy Mining Co. v. Flynn*, 353 F.3d 467, 471 n. 1, 23 BLR 2-44 (6th Cir. 2003); *Director, OWCP v. Siwiec*, 894 F.2d 635, 637 n. 5, 13 BLR 2-259 (3d Cir. 1990).

Ex. No. Date Physician	Age Height Tracings	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify	Impression cooperation comprehension
DX-10 06-24-02 Simpao	56 66"/72" yes (incl flow vol loop)	3.23	3.61	89%	63	No	"good" cooperation and comprehension "reduced vital capacity ... mild restrictive airway disease"
EX-1 02-18-04 Rosenberg	58 71" yes	2.42 2.81	2.74 2.88	88% 98%	92 107	No No	"incomplete effort" "poor" cooperation flow volume curves indicate submaximal effort.
EX-1 08-29-02 Rosenberg	56 72" yes	3.31	3.89	85%	145	No	"good" cooperation and comprehension "mild restrictive airway disease" by spirometry and lung volumes according to Dr. R. V. Mettu.

[4] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 BLR 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116, 19 BLR 2-70 (4th Cir. 1995). There is some variance in the Claimant's recorded height. The report of the study conducted by Dr. Simpao shows different heights -- 66" and 72". The remaining height measurements are 71" and 72". I find that the measurement of 66" is an anomaly, and find that Claimant's average height is 71.70". Assuming a height of 66", the ventilatory tests are still non-qualifying.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies performed before January 19, 2001, are found at 20 CFR § 718.105 (2000), while the quality standards for tests conducted subsequent to that date are set forth at 20 CFR § 718.105 (2004). The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values that are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000); 20 CFR § 718.105(b) (2004).

The following arterial blood gas study evidence has been admitted into the record.

Exhibit Number	Date Altitude	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify	Impression
DX-10	06-24-02 <2999'	Simpao	40.3	98.4	No	No exercise because of pain on exertion; Aa gradient within normal limits
EX-1	08-29-02 not shown	Rosenberg	37.0	86.3	No	
EX-1	02-18-04 not shown	Rosenberg	33.3	96.9	No	normal oxygenation, acute respiratory alkalosis

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, and whether the miner is totally disabled. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR § 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 BLR 1-22 (1986). *See Martin v. Ligon Preparation Co.*, 400 F.3d at 306. The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies,

electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004).

Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). With certain specified exceptions, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). Quality standards for reports of physical examinations performed before January 19, 2001, are found at 20 CFR § 718.104 (2000), while the applicable standards for physical examinations coming after that date are set forth at 20 CFR.§ 718.104 (2004).

The record contains the following medical opinions relating to this case.

Dr. Valentino Simpao

Dr. Simpao examined the Claimant at the request of the Department of Labor.[5] He submitted his report of this examination on June 24, 2002. DX-9. Dr. Simpao recorded a medical history of wheezing attacks, heart disease and hypertension. Mr. Swafford told the doctor that he had never smoked. He complained presently of wheezing, a daily productive cough dyspnea on exertion, chest pain, orthnopnea, including paroxysmal nocturnal orthnopnea. Mr. Swafford said he would become short of breath walking "around 100 ft," that he would notice a change in his breathing after climbing two flights of stairs, and reported that he could lift 40 lbs. but could not carry that weight far. Dr. Simpao observed the Claimant walk 150 feet, and climb ten steps before he became short of breath.

On physical examination, Dr. Simpao observed that Claimant's color was "slightly plethoric." The chest examination revealed "tactile fremitus increased right over left" on palpation. On percussion of the chest, Dr. Simpao observed an "increased resonance [in the] upper chest & auxiliary areas." He observed "crepitation" on auscultation of the chest. Other extremities were normal in appearance.

Dr. Simpao diagnosed "CWP 1/1," and explained this diagnosis on the basis of "multiple years of coal dust exposure[.]" He also opined that the "multiple years" of exposure "is medically significant in [the Claimant's] pulmonary impairment." He concluded that the Claimant suffered from a "mild impairment." On a separate sheet, he reiterated his diagnosis of an occupational lung disease caused by the Claimant's coal

[5] I find that Dr. Simpao's evaluation satisfies the Department's obligation to provide the Claimant with a complete and credible pulmonary evaluation. *See* 30 U.S.C. §923(b), as implemented by 20 C.F.R. §§ 718.102, 725.405 and 725.406. *See also Hodges v. BethEnergy Mines Corp.*, 18 BLR 1-84 (1994).

mine employment, *viz*. pneumoconiosis, and concluded that Mr. Swafford's mild impairment would prevent him from performing the work of a coal miner in a dust free environment.

Dr. Simpao is board certified in internal medicine with a subspecialty in pulmonary disease. CX-1.

Dr. David M. Rosenberg

Dr. Rosenberg has examined the Claimant on two occasions. He first saw Mr. Swafford on August 29, 2002, and then on February 18, 2004. His latest report, dated March 9, 2004, is admitted as EX-1 and reflects Dr. Rosenberg's examinations as well as his review of the other medical records.

The Claimant first presented with complaints of fatigue and "trouble breathing." He told Dr. Rosenberg that he would become short of breath on climbing eight steps, walking 20 yards on level ground and in walking up an incline. He also complained that he would cough, with occasional sputum production but no wheezing. Mr. Swafford suffered from three pillow orthnopnea and would occasionally awaken with shortness of breath.

Dr. Rosenberg recorded that the Claimant was then taking a number of medications, including Toprol, Lotrel, Allopurinol, Zocor and Aspirin. The Claimant had a history of gout and a prior hospitalization for pneumonia. He is a non-smoker, and told Dr. Rosenberg that he worked for 21 years in the mines, spending that entire period as a heavy equipment mechanic on surface mining in conditions that were quite dusty. This work required the Claimant to lift up to 100 lbs. Mr. Swafford told Dr. Rosenberg that he left the mines in 1996 for health reasons, "feeling run down and tired." At the later of the two evaluations, the Claimant told Dr. Rosenberg that he had suffered a myocardial infarction and that stents had been inserted. He complained that his breathing had become worse. About six months prior to the February medical examination, the Claimant suffered "pre-infarction angina." More stents were inserted, and Mr. Swafford would take Nitroglycerin tablets as needed.

On the physical examination conducted on August 29, 2002, Dr. Rosenberg observed no rales, rhonchi, wheezes, murmurs, gallops or rubs. The Claimant exhibited no cyanosis, edema or clubbing on examination of the extremities. Dr. Rosenberg administered clinical testing and took a chest x-ray. During the February, 2004 examination, Dr. Rosenberg observed equal expansion of the chest, without rales, rhonchi or wheezes. Again, Mr. Swafford showed no edema, cyanosis or clubbing. Dr. Rosenberg conducted additional testing for this latter evaluation.

Based on the above procedures and review, Dr. Rosenberg summarized his findings:

> In SUMMARY, Mr. Swafford is a 58-year-old who reports decrease in energy over the last 6 to 8 years and has occasional cough and sputum production. He has had significant coronary artery disease for which he is being treated and recently had a myocardial infarction 6 months ago. He has been a nonsmoker throughout his lifetime and described 21 years of coal mine employment. On examination his lungs were clear. His chest X-ray revealed no micronodularity, and his blood gases were normal. His pulmonary function tests were performed with incomplete efforts, but he was able to achieve a normal MVV after bronchodilators. His diffusing capacity corrected for lung volumes was normal, as was his FEV1 after bronchodilators. His FEV1% was not reduced. Pulmonary function tests performed several years ago were essentially normal.
>
> EX-1.

Dr. Rosenberg then concluded:

> Based on a review of the above information, it can be appreciated that Mr. Swafford's chest X-ray does not reveal the micronodular changes associated with past coal dust exposure. Also, on auscultation of his chest, his lung fields were clear; he did not have chronic end inspiratory rales. With his post FEV1 being normal and previous pulmonary function tests being much improved compared to now, I seriously doubt that he has any restriction even though efforts were not maximal at the present time. His diffusing capacity corrected for lung volumes was normal indicating that the alveolar capillary bed within his lungs is intact. Clearly, when all of the above information is looked at in total, Mr. Swafford does not have the interstitial form of coal workers pneumoconiosis (CWP).
>
> From a functional perspective, Mr. Swafford probably has no significant pulmonary impairment with his MVV being normal after bronchodilators. If he had performed the tests with complete efforts, everything would have been normal. Additionally, his diffusing capacity was normal, as was his blood gas. Clearly, from a pulmonary perspective, he could perform his previous coal mining job or other similarly situated arduous types of labor. Undoubtedly, his whole person impairments relate to his heart, which is consequent to significant coronary artery disease and several myocardial infarctions. This heart condition has not been caused or hastened by past coal dust exposure. With his FEV1% (FEV1/FVC) being normal, he does not have chronic obstructive lung disease.

> In CONCLUSION, it can be stated with a reasonable degree of medical certainty, that Mr. Swafford does not have CWP or associated impairment. From a pulmonary perspective, he could perform his previous coal mining job.

EX-1.

Dr. Rosenberg is board certified in internal medicine, pulmonary disease, and occupational medicine. He was an Assistant Professor of Medicine at the Case Western Reserve University School of Medicine from 1979 to 1985, and is currently an Assistant Clinical Professor at that university. EX-2.

Dr. Lawrence Repsher

Dr. Repsher reviewed the Claimant's medical records at the behest of the Employer, and reported his conclusions on June 15, 2004. EX-3. After surveying the pulmonary function studies of record, Dr. Repsher concluded:

> Pulmonary function tests reveal uninterpretable spirometry, because of poor to extremely poor effort and cooperation with the testing. However, the effort independent testing of the diffusing capacity was entirely normal, which would rule out any clinically significant interstitial lung disease, such as coal workers pneumoconiosis. Further, the post bronchodilator MVV was normal in February 2004, which would also rule out any spirometric impairment. The arterial blood gas tests have been normal to supranormal on all occasions.

EX-3.

Turning to the medical report from Dr. Simpao, Dr. Repsher offered the following critique:

> It should be pointed out that mild impairment on pulmonary function tests would in no way prevent someone from working as a coal miner or any other job. Finally, Mr. Swafford actually does not have mild pulmonary impairment. He clearly has normal lung function, according to his most recent pulmonary function tests in February 2004.
>
> Dr. Repsher recorded the following impression:
>
> 1. No evidence of coal workers pneumoconiosis.
>
> 2. No evidence of any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment as a coal miner with exposure to coal mine dust.

3. Coronary artery disease, severe, status post acute MI, CABG surgery, and recent angioplasty with stent, complicated by current angina pectoris and a 17 year history of ventricular congestive heart failure.

4. Hypertension, unknown cause, poorly controlled despite therapy.

5. Recent gouty arthritis.

Comments and recommendations: As a result of the above, it is my opinion that Mr. Dennis Swafford is not now and never has suffered from coal workers pneumoconiosis or any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment as a coal miner for the Mountain Clay, Inc., with exposure to coal mine dust. My reasons for these opinions are as follows:

1. He has never had any credible radiographic evidence of coal workers pneumoconiosis.

2. His pulmonary function tests, when adjusted for extremely poor effort and cooperation, have been entirely normal.

3. His arterial blood gas tests have always been normal.

4. He is suffering from a number of serious medical illnesses, most importantly severe and progressive coronary artery disease. However, none of these illnesses, including the coronary artery disease, can be fairly attributed to his work as a coal miner with exposure to coal mine dust. Rather, these are diseases of the general population, that are primarily related to heredity and lifestyle factors. Also, from a pulmonary point of view, Mr. Swafford clearly retains the physical capacity to work at any job in the coal mine, even a job that requires continuous heavy exertion.

EX-3.

Dr. Repsher is board certified in internal medicine with a subspecialty in pulmonary disease and is a B-reader. He is an Associate Clinical Professor of Medicine, Division of Pulmonary Sciences, at the University of Colorado. EX-4.

Deposition Testimony

Dr. Rosenberg's deposition testimony was recorded on July 9, 2004.[6] EX-5. The subject of this testimony was the pulmonary evaluations of the Claimant that he conducted on August 29, 2002, and February 18, 2002. EX-5 at 19. He noted that with 21 years of coal mine dust exposure, the period of exposure experienced by the Claimant, a miner could "develop various forms of pneumoconiosis of the simple or complicated variety. One could also develop legal forms of pneumoconiosis, such as airflow obstruction, silicotuberculosis, cor pulmonale, [etc.]." EX-5 at 20.

Dr. Rosenberg reviewed the protocols of the two examinations of Mr. Swafford that were conducted by him. He noted that the second pulmonary function test that was conducted in his office was invalid, and concluded that, based on the studies, the Claimant "probably has no significant impairment based on the post-bronchodilator normal FEV1 and MVV." EX-5 at 21. He explained that a patient who is able to achieve normal results would "probably have normal lung function." *Id*.

Dr. Rosenberg explained his conclusion that the Claimant does not have pneumoconiosis:

> ... He doesn't have medical pneumoconiosis, first, his chest x-ray did not reveal any micro nodularity; second of all, his pulmonary function test with good effort did not demonstrate restriction; he had no reduction of lung volume based on his normal total lung capacity; his oxygenation is normal; and on listening with a stethoscope, he had no rales. So he had no manifestation of interstitial lung disease. So he doesn't have a medical form of pneumoconiosis. From a legal perspective, he really – he does not have chronic obstructive pulmonary disease; his FEV1% is normal; he has no manifestation of any pulmonary condition, which is caused or hastened by coal dust exposure.

EX-5 at 22-23.

Pertaining to an assessment of any pulmonary or respiratory impairment, Dr. Rosenberg opined:

> From a respiratory perspective, he has no significant respiratory impairment overall; he has no significant obstruction; any restriction that has been measured is related probably to incomplete effort; his oxygenation is normal; his chest x-rays do not show any micro nodularity related to coal dust exposure.

EX-5 at 23.

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[6] Dr. Rosenberg was initially questioned about general concepts of a pulmonary evaluation, and acknowledged that pneumoconiosis can cause an obstructive obstruction. EX-5 at 14-15.

Rebuttal Evidence

The Employer submitted a consultation report by Dr. Matthew A. Vuskovich, who reviewed the Claimant's June 24, 2002 arterial blood gas and pulmonary function tests. In his report, dated April 22, 2004, Dr. Vuskovich concluded with respect to the pulmonary function test results:

> Though invalid, 6/24/2002 spirometry results are normal, or demonstrate mild impairment. With maximum effort, subject generated values could only be greater. If Mr. Swafford stands 72 inches, then the values generated, though invalid are inconsistent with mild impairment. ... All other factors being equal, (i.e., oxygen diffusion capacity, intact respiratory muscles, intact cardiovascular system), even if 6/24/2002 spirometry results were valid, the worker with mild impairment measured with spirometry utilizing standardized methods, from a pulmonary standpoint can perform most arduous work tasks including those required for successful coal industry employment.

EX-6.

Dr. Vuskovich is board certified in occupational medicine, and is a B-reader. EX-7.

DISCUSSION

Pneumoconiosis

It must be emphasized that, purposes of the Act, pneumoconiosis means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. A disease arising out of coal mine employment includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201.

Because this claim arises within the territorial jurisdiction of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at 20 CFR §718.202(a). *Cornett v. Benham Coal*, *Inc.*, 227 F.3d 569, 575, 22 BLR 2-107 (6th Cir. 2000). *See Furgerson v. Jericol Mining, Inc.*, 22 BLR 1-216 (2002) (en banc). There are four methods for determining the existence of pneumoconiosis. Under 20 CFR § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. A claimant may establish the presence of pneumoconiosis at Section 718.202(a)(2), upon the basis of autopsy or biopsy evidence. Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions apply. The Secretary's regulations also provide that a miner may establish the existence of pneumoconiosis under Section

718.202(a)(4) on the basis of a medical opinion diagnosis of pneumoconiosis, notwithstanding a negative x-ray. 20 CFR § 718.202(a)(4).

X-Ray Evidence: 20 CFR § 718.202(a)(1)

The record contains the interpretations of three chest x-rays. The first film was taken and read by Dr. Simpao on June 24, 2002 at the request of the Department of Labor. DX-10. Dr. Simpao interpreted this film as positive for pneumoconiosis. DX-10. Dr. Barrett read the film for quality only, concluding that the film was a "quality 1" radiograph. DX-10. On October 11, 2002, Dr. Poulos, a board certified radiologist and B-reader, reread this film a negative for pneumoconiosis. DX-11. I credit the interpretation of this x-ray by Dr. Poulos on the basis of his dual credentials. *Roberts*. *See Staton v. Norfolk & Western Railway Co.*, 65 F.3d 55, 59, 19 BLR 2-271 (6th Cir. 1995). The second and third x-rays were taken on August 29, 2002 and February 18, 2004, with each film interpreted as "0/0", or negative, by Dr. Rosenberg, who was a B-reader at the time the films were read. EX-1. There are no contrary positive readings of these x-rays, and I therefore find that they do not establish the presence of pneumoconiosis.

Based on the above chest x-ray evidence, I find that the Claimant has failed to establish that he suffers from pneumoconiosis at Section 718.202(a)(1). I find, viewing the x-ray evidence qualitatively as well as quantitatively, *see Woodward v. Director*, *OWCP*, 991 F.2d 314, 321, 17 BLR 2-77 (6th Cir. 1993), that the preponderance of the x-ray evidence is negative.

Biopsy or Autopsy Evidence pursuant to 20 CFR § 718.202(a)(2)
Applicable Presumptions

The Claimant cannot establish pneumoconiosis at Section 718.202(a)(2), because the record contains no evidence relevant to that provision. The Claimant is likewise precluded from the benefit of the presumptions accorded under Section 718.202(a)(3), because there is no evidence of complicated pneumoconiosis. Sections 718.305 and 718.306 do not apply because this claim was filed after January 1, 1982.

Medical Opinion Evidence pursuant to 20 CFR § 718.202(a)(4)

The final provision under which the Claimant may establish the existence of pneumoconiosis is at Section 718.202(a)(4), on the basis of a medical opinion diagnosis of the disease, notwithstanding a negative x-ray. A qualifying diagnosis could not only be "clinical" pneumoconiosis, as that disease process is ordinarily diagnosed in the clinical setting, but also "legal" pneumoconiosis. Pneumoconiosis is defined broadly under the Act, and any pulmonary or respiratory impairment significantly related to, or substantially aggravated by, the Miner's coal mine dust exposure will qualify as the disease. *See generally Southard v. Director, OWCP*, 732 F.2d 66, 6 BLR 2-26 (6th Cir. 1984). Certainly, obstructive lung disease may constitute pneumoconiosis under the Act, *see Kline v. Director, OWCP*, 877 F.2d 1175, 1178, 12 BLR 2-346 (3d Cir. 1989),

provided it is proven to have been significantly related to or substantially aggravated by Claimant's coal mine dust exposure. *See Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 341, 20 BLR 2-246 (4th Cir. 1996). *See generally* 65 Fed. Reg. 79943 (Dec. 20, 2000) (citing cases).

Dr. Simpao rendered a positive diagnosis of pneumoconiosis, specifically noting "CWP 1/1," and explaining his conclusion on the basis of the Claimant's coal mine dust exposure. I find that his medical opinion does not persuasively establish that Mr. Swafford has either clinical or the broadly defined "legal" pneumoconiosis.

Initially, it appears that, in view of the specific diagnosis of "CWP 1/1," Dr. Simpao has merely restated in his opinion his positive reading of the June 24, 2002 x-ray. This does not constitute a medical opinion diagnosis of pneumoconiosis at Section 718.202(a)(4). *See Worhach*.[7] *See also Cornett*, 227 F.3d at 576. Second, I discount the diagnosis by Dr. Simpao to the extent his conclusions, that Claimant has pneumoconiosis, rests in part on a positive x-ray that has been reread as negative. *See Winters v. Director, OWCP*, 6 BLR 1-877 (1984). While a medical opinion diagnosis of pneumoconiosis may be sufficient *notwithstanding* a negative x-ray, *see Taylor v. Director, OWCP*, 9 BLR 1-22 (1996), where x-ray evidence constitutes a major part of the physician's documentation, his opinion may be entitled to diminished probative weight if *that* film has been reread as negative. *Cf. Director, OWCP v. Rowe*, 710 F.2d 251, 255 n. 6, 5 BLR 2-99 (6th Cir. 1983) (validity of opinion discounted because doctor relied on x-ray found to be unreadable). Thus, even if the diagnosis of "CWP 1/1" constitutes more than a mere reference to a positive x-ray, the negative rereading of this film by a more qualified radiologist detracts from the probative value of Dr. Simpao's diagnosis.

Finally, I find in the alternative that Dr. Simpao's medical opinion does not establish the existence of pneumoconiosis at Section 7128.202(a)(4) because I credit instead the conflicting medical opinions of Dr. Rosenberg and Repsher. The former physician examined the Claimant on two occasions, and provided a well documented and reasoned explanation as to why the Claimant does not suffer from coal workers' pneumoconiosis even as that disease is broadly defined in the Act.

In the final analysis, I find that the medical opinion by Dr. Rosenberg is sufficient to preclude a finding of pneumoconiosis at Section 718.202(a)(4). Dr. Rosenberg observed no positive findings on examinations of the chest or extremities. His opinion is otherwise supported by a negative x-ray, and normal clinical testing. Such testing serves as part of the acceptable documentation for a medical opinion diagnosis of pneumoconiosis. 20 CFR § 718.202(a)(4). I find that his conclusions are better

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[7] In *Cornett v. Benham Coal Co.*, 227 F.3d 569, 22 BLR 2-107 (6th Cir. 2000), the Sixth Circuit faulted the administrative law judge's incorrect characterization of a medical opinion as a mere restatement of an x-ray. Unlike the record before the Court of Appeals, Dr. Simpao's medical report does not conclude that the positive findings on examination and testing of Mr. Swafford demonstrate "sufficient objective and clinical evidence to justify a diagnosis of coal workers' pneumoconiosis notwithstanding a negative x-ray." 227 F.3d at 576.

supported by this underlying documentation. *See Clark v. Karst-Robbins Corp.*, 12 BLR 1-149 (1989) (*en banc*); *Lucostic v. United States Steel Corp.*, 8 BLR 1-46 (1985). I also note that Dr. Rosenberg's opinion is based as well on a review of other medical evidence. *See Balsavage v. Director*, *OWCP*, 295 F.3d 390, 397, 22 BLR 2-386 (3d Cir. 2002) (opinion of physician who did not address other medical records accorded less weight). Finally, Dr. Rosenberg also specifically confronts the "legal" definition of pneumoconiosis when he testified at deposition. EX-5 at 20. I find that, on balance, the medical report by Dr. Rosenberg is better documented and reasoned, and more credible. *See Rowe*. His conclusions are also supported by the opinion of Dr. Repsher, who reviewed Mr. Swafford's record.

In assessing the probative value of a medical opinion, I must account for "the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 441, 21 BLR 2-269 (4th Cir. 1997). *See Underwood v. Elkay Mining, Inc*., 105 F.3d 946, 950-951, 21 BLR 2-23 (4th Cir. 1997). Dr. Rosenberg's conclusions meet these criteria on this record. I therefore find that the Claimant has not proven by a preponderance of the medical opinion evidence that he suffers from pneumoconiosis as that disease is expansively defined in the Act.

Because the Claimant has failed to establish the existence of pneumoconiosis under any method available at Section 718.202(a), I find that benefits must be denied because of his failure to prove a necessary element of entitlement. *Perry, supra*.

Total Respiratory Disability

I also find that, assuming that the Claimant was successful in establishing the existence of pneumoconiosis, he would not establish the existence of a totally disabling pulmonary or respiratory impairment. 20 CFR § 718.204(b)(2). A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304, or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c). I emphasize that *any* loss in lung function may qualify as a total respiratory disability under Section 718.204(b)(2). *See Carson v. Westmoreland Coal Co.*, 19 BLR 1-16 (1964), *modified on recon*. 20 BLR 1-64 (1996).

The Claimant testified that, as a heavy equipment mechanic, he would be required to lift equipment well in excess of fifty pounds. I find that his employment was strenuous heavy labor.

The Regulations provide a number of methods to show total disability other than by the presence of complicated pneumoconiosis: (i) pulmonary function studies; (ii) blood gas studies; (iii) evidence of cor pulmonale; (iv) reasoned medical opinion; and in certain limited circumstances, lay testimony. 20 CFR §§ 718.204(b)(2) and (d) (2004).

Lay testimony may also constitute relevant evidence. *See Madden v. Gopher Mining Co.*, 21 BLR 1-122 (1999). A finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony, however. 20 CFR § 718.204(d) (2002). *See Tedesco v. Director, OWCP*, 18 BLR 1-103 (1994). *See also, Fife v. Director, OWCP,* 888 F.2d 365, 370, 13 BLR 2-109 (6th Cir. 1989).

There is no evidence in the record that Claimant suffers from complicated pneumoconiosis or cor pulmonale. Further, I find that Claimant has failed to demonstrate total respiratory disability at 20 CFR §§ 718.204(b)(2)(i) or (2)(ii). Not one of the ventilatory or arterial blood gas tests produced results that qualify under the Secretary's regulations.

The final provision under which a miner can prove that he suffers from a total pulmonary or respiratory disability is on the basis of a reasoned medical opinion. 20 CFR § 718.204(b)(2)(iv). At the outset, I find that Dr. Simpao's assessment, that the Claimant suffers from a "mild" pulmonary or respiratory impairment, does constitute an assessment of total respiratory disability, because Dr. Simpao specifically opined that this level of impairment would preclude Mr. Swafford from returning to his former coal mine employment. I disagree with Dr. Repsher's opinion to the extent that an assessment of a mild impairment would never be totally disabling. *See also* EX-6 (Dr. Vuskovich). Again, I will accept Dr. Simpao's assessment that a mild impairment does prevent Mr. Swafford from returning to the mines.

Having said that, upon consideration of the medical opinion evidence, I do find that the Claimant has failed to demonstrate total respiratory disability at Section 718.204(b)(2)(iv). The medical opinion evidence is in conflict. First, the objective clinical studies administered by Dr. Simpao do not demonstrate qualifying values. Although a medical opinion of total disability does not require objective support from the physician's clinical testing, *see Cornett*, 227 F.3d at 57, the results of such testing form part of the basis of the clinical documentation for their opinions. *See Clark v. Karst-Robbins Corp.*, 12 BLR 1-149 (1989) (*en banc*); *Lucostic v. United States Steel Corp.*, 8 BLR 1-46 (1985). In this regard, I consider the disability assessment by Dr. Rosenberg to be better documented and reasoned. While I duly note that Dr. Mettu, in reviewing the ventilatory test of August 29, 2002, found the results indicated a "mild restrictive airway disease," EX-1, I nonetheless find that this interpretation does not detract from the weight of Dr. Rosenberg's assessment that the Claimant is not totally disabled.

Moreover, I credit to some extent Dr. Vuskovich's invalidation of the pulmonary function study conducted by Dr. Simpao. EX-6. *Peabody Coal Co. v. Director, OWCP* [*Brinkley*], 972 F.2d 882, 883, 16 BLR 2-129 (7th Cir. 1992) ("[a]lthough the tests ... were qualifying and conforming, they must also be valid."). *See generally Andruscavage v. Director, OWCP*, No. 93-3291 (3d Cir. Feb. 22, 1994) (unpub.) (court affirms administrative law judge's reliance on consultants who, in part, utilized this rationale).

In the final analysis, I credit the opinions of Drs. Rosenberg, as supported by Dr. Repsher, that Mr. Swafford is not precluded from returning to the mines, over the contrary opinion by Dr. Simpao. I find that Dr. Rosenberg's analysis, especially as tested in deposition testimony, is more extensive, and is better supported by the clinical testing in the record as a whole. Claimant has not demonstrated total respiratory disability at Section 718.202(b)(2)(iv). I have considered Claimant's testimony, and have gauged the medical opinion disability assessments in light of this testimony regarding the nature of his usual coal mine work. *See generally Onderko v. Director, OWCP*, 14 BLR 1-2 (1988). I have also considered the fact that the Claimant received a black lung award from the Commonwealth of Kentucky.

Finally, after independently weighing all relevant evidence pursuant to 20 CFR § 718.204(b)(2), like and unlike, including lay testimony, and considering the heavy exertional requirements of a heavy equipment mechanic, I nevertheless find that the Claimant has not established total respiratory disability. *See Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986), *aff'd on recon. en banc.*, 9 BLR 1-236 (1987). *See also Poole v. Freeman United Coal Mining Co.*, 897 F.2d 888, 894, 13 BLR 2-348 (7th Cir. 1990). In the final analysis, the conflicting opinions of Drs. Rosenberg and Repsher, as well as the non-qualifying clinical tests of record, constitute contrary probative evidence that precludes the Claimant from establishing total respiratory disability.

Because the Claimant has not established by a preponderance of the record evidence that he suffers from pneumoconiosis, or a totally disabling pulmonary or respiratory impairment, I find that he has not established entitled to benefits under the Act.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which Claimant is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of attorney's fees to the Claimant for representation services rendered in pursuit of the claim.

ORDER

The claim of Dennis Swafford for benefits under the Act is denied.

A

WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:dj

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.